Therapy Intake Form

(*Personal & Confidential*) Date : ___________________

Name ______________________________ Address_________________________________

City / Prov ___________________________ Postal Code _____________________________

Cell # / phone ________________________ Date of Birth ____________________________

Occupation ___________________________ E-mail __________________________________

Are you presently under a Dr's care? If Yes, explain ____________________________________

____

Are you on any medication / supplements ? List

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Do you currently have any of the following conditions? Please check if Yes

☐	High blood pressure	☐	Allergies	☐	Diabetic/ Hypogly
☐	Heart Disease	☐	Kidney Disease	☐	Headaches
☐	Depression/Anxiety	☐	Stress	☐	Pregnant
☐	Cancer	☐	Digestive issues	☐	Sleeping problems
☐	Constipation / Diarrhea	☐	Circulation	☐	Epilepsy / Neurological
☐	Arthritis / Joint	☐	Menstral / Meno	☐	Gallbladder / liver
☐	Do you smoke	☐	Drink Alcohol	☐	Drug addiction

Do you have any other medical conditions, that I should be aware of ?

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List any surgeries, fractures, accidents

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____

What do you hope to achieve out of this session & subsequent sessions ?

____

Did you have any trauma at birth ? Forceps ____ C-Section ____ Suction ____ Normal ______

How would you rate your general physical health? Good _____ Fair _____ Poor _____

Explain

____

How would you rate your emotional well being ? Good _____ Fair _______ Poor ______

Explain

____

What do you do for physical activity ?

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Is there anything else you would like to tell me ?

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____

I consent to receiving a therapy session (s). From Darlene Klassen O/A Full Circle Wholistic Therapy. A Wholistic Practitioner - Therapist is not a Dr. I do not diagnose or prescribe for. I release the Therapist from any & or all liability as a result from this session (s) , or consequences following session (s). The therapist is not held responsible for any medical information not given, with held or in-complete.

Signature ______________________________ Print Name _______________________________

Client or Parent/ Guardian

IN CASE OF EMERGENCY CONTACT

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